CHAPTER 83
MEDICAID WAIVER SERVICES

PREAMBLE

Medicaid waiver services are services provided to maintain persons in their own homes or communities who would otherwise require care in medical institutions. Provision of these services must be cost-effective. Services are limited to certain targeted client groups for whom a federal waiver has been requested and approved. Services provided through the waivers are not available to other Medicaid recipients as the services are beyond the scope of the Medicaid state plan.

DIVISION I—HCBS ILL AND HANDICAPPED WAIVER SERVICES

441—83.1(249A) Definitions.

"Blind individual" means an individual who has a central visual acuity of 20/200 or less in the better eye with the use of corrective lens or visual field restriction to 20 degrees or less.

"Client participation" means the amount of the recipient income that the person must contribute to the cost of ill and handicapped waiver services exclusive of medical vendor payments before Medicaid will participate.

"Deeming" means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

"Disabled person" means an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which has lasted or is expected to last for a continuous period of not less than 12 months. A child under the age of 18 is considered disabled if the child suffers a medically determinable physical or mental impairment of comparable severity.

"Financial participation" means client participation and medical payments from a third party including veterans' aid and attendance.

"Intermittent homemaker service" means homemaker service provided from one to three hours a day for not more than four days per week.

"Intermittent respite service" means respite service provided from one to three times a week.

"Medical institution" means a nursing facility or an intermediate care facility for the mentally retarded which has been approved as a Medicaid vendor.

"Substantial gainful activity" means productive activities which add to the economic wealth, or produce goods or services to which the public attaches a monetary value.

"Third-party payments" means payments from an attorney, individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

441—83.2(249A) Eligibility. To be eligible for ill and handicapped waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.2(1) *Eligibility criteria.*

a. The person must be determined to be one of the following:

(1) Blind or disabled as determined by the receipt of social security disability benefits, or a disability determination made through the division of medical services. Disability determinations are made according to supplemental security income guidelines as per Title XVI of the Social Security Act.

(2) Aged 65 or over and residing in a county that is not served by the HCBS elderly waiver.

b. The person must be ineligible for medical assistance under other Medicaid programs or coverage groups with the exception of: the medically needy program, the in-home, health-related program when the person chooses the ill and handicapped waiver instead of the in-home, health-related program, the HCBS MR waiver when the person is a child under the age of 18 with mental retardation and meets the skilled nursing level of care, cases approved by the intradepartmental board for supplemental security income deeming determinations between 1982 and 1987, and children eligible for supplemental security income under Section 8010 of Public Law 101-239.

c. Persons shall meet the eligibility requirements of the supplemental security income program except for the following:

(1) The person is under 18 years of age, unmarried and not the head of a household and is ineligible for supplemental security income because of the deeming of the parent's(s') income and resources.

(2) The person is married and is ineligible for supplemental security income because of the deeming of the spouse's income or resources.

(3) The person is ineligible for supplemental security income due to excess income and the person's income does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

d. The person must be certified as being in need of nursing facility or skilled nursing facility level of care or as being in need of care in an intermediate care facility for the mentally retarded. The Iowa Foundation for Medical Care shall be responsible for approval of the certification of the level of care.

Ill and handicapped waiver services will not be provided when the individual is an inpatient in a medical institution.

e. Rescinded IAB 12/6/95, effective 2/1/96.

f. The person must meet income and resource guidelines for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified at paragraphs 441—75.5(2)*"b"* and 441—75.5(4)*"c"* shall be applied.

g. The person must have service needs that can be met by this waiver program. At a minimum a person must receive a unit of adult day care, consumer-directed attendant care, counseling, home health aid, homemaker, nursing, or respite service per quarter.

83.2(2) *Need for services.*

a. The consumer shall have a service plan approved by the department which is developed by the county social worker as identified by the county of residence. This service plan must be completed prior to services provision and annually thereafter.

The social worker shall establish the interdisciplinary team for the consumer and, with the team, identify the consumer's need for service based on the consumer's needs and desires as well as the availability and appropriateness of services using the following criteria:

(1) This service plan shall be based, in part, on information in the completed Home- and Community-Based Services Assessment or Reassessment, Form 470-0659. Form 470-0659 is completed annually, or more frequently upon request or when there are changes in the client's condition.

(2) Service plans for persons aged 20 or under shall be developed or reviewed after the child's individual education plan and EPSDT plan, if applicable, are developed so as not to replace or duplicate services covered by those plans.

(3) Those service plans for persons aged 20 or under which include home health, homemaker, nursing, or respite services shall not be approved until a home health agency has made a request to cover the consumer's service needs through EPSDT.

b. The total monthly cost of the ill and handicapped waiver services shall not exceed the established aggregate monthly cost for level of care as follows:

Skilled level of care	Nursing level of care	ICF/MR
$2,480	$852	$3,019

441—83.3(249A) Application.

83.3(1) *Application for HCBS ill and handicapped waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.3(2) *Application and services program limit.* The number of persons who may be approved for the HCBS ill and handicapped waiver shall be subject to the number of clients to be served as set forth in the federally approved HCBS ill and handicapped waiver. The number of clients to be served are set forth at the time of each five-year renewal of the waiver or in amendments to the waiver. When the number of applicants exceeds the number of clients specified in the approved waiver, the applicant's name shall be placed on a waiting list maintained by the division of medical services.

a. The county office shall contact the division of medical services for all applicants for the waiver to determine if a payment slot is available.

(1) For persons not currently receiving Medicaid, the county office shall contact the division of medical services by the end of the second working day after receipt of a completed Form PA-1107-0, Application for Medical Assistance or State Supplementary Assistance.

(2) For current recipients, the county office shall contact the division of medical services by the end of the second working day after receipt of Form 470-0660, Home- and Community-Based Service Report, signed and dated by the recipient or a written request, signed and dated by the recipient.

b. By the end of the third day after the receipt of the completed Form PA-1107-0 or 470-0660, if no payment slot is available, persons shall be entered on a waiting list by the division of medical services according to the following:

(1) Persons not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form PA-1107-0, Application for Medical Assistance or State Supplementary Assistance, is signed or date-stamped in the county office, whichever is later. Clients currently eligible for Medicaid shall be added to the waiting list on the basis of the date Form 470-0660, or a written request, is signed and dated or date-stamped in the county office, whichever is later. In the event that more than one application is received at one time, persons shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

(2) Persons who do not fall within the available slots shall have their application rejected and their names shall be maintained on the waiting list. They shall be contacted to reapply as slots become available based on their order on the waiting list so that the number of approved persons on the program is maintained.

(3) Once a payment slot is assigned, written notice shall be given to the applicant, and the payment slot shall be held for 180 days to arrange services unless the person has been determined ineligible for the program. If services are not initiated within 180 days of the written notice to the applicant, the slot reverts for use by the next applicant on the waiting list, if applicable. The applicant must reapply for a new slot.

83.3(3) *Approval of application.*

a. Applications for the HCBS ill and handicapped waiver program shall be processed in 30 days unless one or more of the following conditions exist:

(1) An application has been filed and is pending for federal supplemental security income benefits.

(2) The application is pending because the department has not received information which is beyond the control of the client or the department.

(3) The application is pending due to the disability determination process performed through the department.

(4) The application is pending because a level of care determination has not been made although the completed assessment, Form SS-1644, has been submitted to the Iowa Foundation for Medical Care.

(5) The application is pending because the assessment, Form SS-1644, or the case plan has not been completed. When a determination is not completed 90 days from the date of application due to the lack of a completed assessment, Form SS-1644, or case plan, the application shall be denied. The client shall have the right to appeal.

b. Decisions shall be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations and the client case plan are completed.

c. A client must be given the choice between HCBS ill and handicapped waiver services and institutional care. The income maintenance or service worker shall have the client or guardian complete and sign Form 470-0660, Home- and Community-Based Service Report, indicating the client's choice of home- and community-based services or institutional care.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

e. A consumer may be enrolled in only one waiver program at a time. Costs for waiver services are not reimbursable while the consumer is in a medical institution (hospital or nursing facility) or residential facility. Services may not be simultaneously reimbursed for the same time period as Medicaid or other Medicaid waiver services.

83.3(4) *Effective date of eligibility.*

a. Deeming of parental or spousal income and resources ceases and eligibility shall be effective on the date the income and resource eligibility and level of care determinations and the case plan are completed, but shall not be earlier than the first of the month following the date of application.

b. The effective date of eligibility for the ill and handicapped waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom paragraphs *"a"* and *"c"* of this subrule do not apply is the date on which the income eligibility and level of care determinations and the case plan are completed.

c. Eligibility for persons covered under subrule 83.2(1)"*c*"(3) shall exist on the date the income and resource eligibility and level of care determinations and case plan are completed, but shall not be earlier than the first of the month following the date of application.

d. Eligibility continues until the recipient has been in a medical institution for 30 consecutive days for other than respite care. Recipients who are inpatients in a medical institution for 30 or more consecutive days for other than respite care shall be terminated from ill and handicapped waiver services and reviewed for eligibility for other Medicaid coverage groups. The recipient will be notified of that decision through Form SS-1104-0, Notice of Decision. If the client returns home before the effective date of the notice of decision and the person's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.3(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

441—83.4(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of ill and handicapped waiver services or other Medicaid services, as applicable.

83.4(1) *Maintenance needs of the individual.* The maintenance needs of the individual shall be computed by deducting an amount which is 300 percent of the maximum monthly payment for one person under supplemental security income (SSI) from the client's total income.

83.4(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker for ill and handicapped waiver services, Medicaid shall make no payments to ill and handicapped waiver service providers. However, Medicaid shall make payments to other medical vendors, as applicable.

83.4(3) *Maintenance needs of spouse and other dependents.* Rescinded IAB 4/9/97, effective 6/1/97.

441—83.5(249A) Redetermination. A complete redetermination of eligibility for the ill and handicapped waiver shall be completed at least once every 12 months or when there is significant change in the person's situation or condition.

A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.7(249A) and 441—83.2(249A). A redetermination shall include verification of the existence of a current case plan meeting the requirements listed in rule 441—83.7(249A).

441—83.6(249A) Allowable services. Services allowable under the ill and handicapped waiver are homemaker services, home health services, adult day care services, respite care services, nursing services, counseling services, and consumer-directed attendant care services as set forth in rule 441—78.34(249A).

441—83.7(249A) Case plan. A case plan shall be prepared for ill and handicapped waiver clients in accordance with rule 441—130.7(234) except that case plans for both children and adults shall be completed every 12 months or when there is significant change in the person's situation or condition. In addition, the case plan shall include the frequency of the ill and handicapped waiver services and the types of providers who will deliver the services.

441—83.8(249A) Adverse service actions.

83.8(1) Denial. An application for services shall be denied when it is determined by the department that:

a. The client is not eligible for or in need of services.

b. Needed services are not available or received from qualified providers.

c. Service needs exceed the aggregate monthly costs established in 83.2(2)*"b,"* or are not met by the services provided.

d. Needed services are not available or received from qualifying providers.

83.8(2) Termination. A particular service may be terminated when the department determines that:

a. The provisions of 130.5(2)*"a," "b," "c," "g,"* or *"h"* apply.

b. The costs of the ill and handicapped waiver service for the person exceed the aggregate monthly costs established in 83.2(2)*"b."*

c. The client receives care in a hospital, nursing facility, or intermediate care facility for the mentally retarded for 30 days in any one stay for purposes other than respite care.

d. The client receives ill and handicapped waiver services and the physical or mental condition of the client requires more care than can be provided in the client's own home as determined by the service worker.

e. Service providers are not available.

83.8(3) Reduction of services shall apply as in subrule 130.5(3), paragraphs *"a"* and *"b."*

441—83.9(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234). The applicant or recipient is entitled to have a review of the level of care determination by the Iowa Foundation for Medical Care by sending a letter requesting a review to the foundation. If dissatisfied with that decision, the applicant or recipient may file an appeal with the department.

441—83.10(249A) County reimbursement. Rescinded IAB 4/9/97, effective 6/1/97.

441—83.11(249A) Conversion to the X-PERT system. For conversion to the X-PERT system at a time other than review, the recipient may be required to provide additional information. To obtain this information, a recipient may be required to have an interview. Failure to respond for this interview when so requested, or failure to provide requested information, shall result in cancellation.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.12 to **83.20** Reserved.

DIVISION II—HCBS ELDERLY WAIVER SERVICES

441—83.21(249A) Definitions.

"Client participation" means the amount of the recipient income that the person must contribute to the cost of elderly waiver services exclusive of medical vendor payments before Medicaid will participate.

"*Interdisciplinary team*" means a collection of persons with varied professional backgrounds who develop one plan of care to meet a client's need for services.

"*Iowa Foundation for Medical Care*" means the entity designated by the federal government to be the peer review organization for the state of Iowa.

"*Long-term care coordinating unit designated case management project for frail elderly*" means the case management system which conducts interdisciplinary team meetings to develop and update care plans for persons aged 65 and older.

"*Medical institution*" means a nursing facility which has been approved as a Medicaid vendor.

"*Project coordinator*" means the person designated by the administrative entity to oversee the long-term care coordinating unit's designated case management project for the frail elderly.

"*Third-party payments*" means payments from an individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

441—83.22(249A) Eligibility. To be eligible for elderly waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.22(1) *Eligibility criteria.* All of the following criteria must be met. The person must be:

a. Sixty-five years of age or older.

b. A resident of the state of Iowa.

c. Eligible for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified at 441—paragraphs 75.5(2)"*b*" and 75.5(4)"*c*" shall be applied.

d. Certified as being in need of the intermediate or skilled level of care. The Iowa Foundation for Medical Care shall be responsible for approval of the certification of the level of care.

Elderly waiver services will not be provided when the person is an inpatient in a medical institution.

e. Determined to need services as described in subrule 83.22(2).

f. Under the case management of a member of the long-term care coordinating unit designated case management project for the frail elderly.

83.22(2) *Need for services.*

a. Applicants for elderly waiver services shall have an assessment of the need for service and the availability and appropriateness of service. The tool used to complete the assessment shall be the assessment tool designated by the long-term care coordinating unit established at Iowa Code section 231.58. The assessment shall be completed by the designated case management project for the frail elderly in the community or the local service worker. The Iowa Foundation for Medical Care shall be responsible for determining the level of care based on the completed assessment tool and supporting documentation as needed.

b. The total monthly cost of the elderly waiver services shall not exceed the established monthly cost of the level of care. Aggregate monthly costs are limited as follows:

Skilled level of care	Nursing level of care
$2,480	$852

83.22(3) *Providers—standards.* Participants in the waiver shall be case managed by providers who meet all the following standards:

a. Be a member of the long-term care coordinating unit designated case management project for the frail elderly.

b. Have a bachelor's degree in a human services field or be currently licensed as a registered nurse. Up to two years, relevant experience may be substituted for two years of the educational requirement.

c. Have formal training in completion of the assessment tool.

d. Receive formal case management training as specified by the long-term care coordinating unit.

441—83.23(249A) Application.

83.23(1) *Application for HCBS elderly waiver.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.23(2) *Application for services.* Rescinded IAB 12/6/95, effective 2/1/96.

83.23(3) *Approval of application.*

a. Applications for the elderly waiver program shall be processed in 30 days unless the worker can document difficulty in locating and arranging services or circumstances beyond the worker's control. In these cases a decision shall be made as soon as possible.

b. Decisions shall be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

c. An applicant must be given the choice between elderly waiver services and institutional care. The client or guardian shall sign Form 470-3156, Long-Term Care Coordinating Unit Common Care Plan, indicating the client's choice of caregiver.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

83.23(4) *Effective date of eligibility.*

a. The effective date of eligibility cannot precede the date the department service worker signs the case plan. Applicants without a case plan signed by the department service worker are not eligible for the waiver.

b. Eligibility for persons whose income exceeds supplemental security income guidelines shall not exist until the persons require care in a medical institution for a period of 30 consecutive days and shall be effective no earlier than the first day of the month in which the 30-day period begins.

c. Eligibility continues until the recipient has been in a medical institution for 30 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.22(249A). Recipients who are inpatients in a medical institution for 30 or more consecutive days for other than respite care shall be terminated from elderly waiver services and reviewed for eligibility for other Medicaid coverage groups. The recipient will be notified of that decision through Form SS-1104-0, Notice of Decision. If the client returns home before the effective date of the notice of decision and the person's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.23(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

441—83.24(249A) Client participation. Persons must contribute their predetermined client participation to the cost of elderly waiver services.

83.24(1) *Computation of client participation.* Client participation shall be computed by deducting an amount for the maintenance needs of the individual which is 300 percent of the maximum SSI grant for an individual from the client's total income.

83.24(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker, Medicaid will make no payments for elderly waiver service providers. However, Medicaid will make payments to other medical vendors.

441—83.25(249A) Redetermination. A complete redetermination of eligibility for elderly waiver services shall be done at least once every 12 months.

A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.22(249A). A redetermination shall contain the components listed in rule 441—83.27(249A).

441—83.26(249A) Allowable services. Services allowable under the elderly waiver are adult day care, emergency response system, homemaker, home health aide, nursing, respite care, chore, home-delivered meals, home and vehicle modification, mental health outreach, transportation, nutritional counseling, assistive devices, senior companions, and consumer-directed attendant care services as set forth in rule 441—78.37(249A).

441—83.27(249A) Case plan. Form 470-3156, Long-Term Coordinating Unit Common Care Plan, shall be completed jointly by the area agency on aging case management program for the frail elderly and department service worker.

441—83.28(249A) Adverse service actions.

83.28(1) *Denial.* An application for services shall be denied when it is determined by the department that:

a. The client is not eligible for or in need of services.

b. Except for respite care, the elderly waiver services are not needed on a regular basis.

c. Service needs exceed the aggregate monthly costs established in 83.22(2)*"b,"* or are not met by services provided.

d. Needed services are not available or received from qualifying providers.

e. Rescinded IAB 3/2/94, effective 3/1/94.

83.28(2) *Termination.* A particular service may be terminated when the department determines that:

a. The provisions of 441—subrule 130.5(2), paragraph *"a," "b," "c," "d," "g,"* or *"h"* apply.

b. The costs of the elderly waiver services for the person exceed the aggregate monthly costs established in 83.22(2)*"b."*

c. The client receives care in a hospital or nursing facility for 30 days in any one stay for purposes other than respite care.

d. The client receives elderly waiver services and the physical or mental condition of the client requires more care than can be provided in the client's own home as determined by the service worker.

e. Service providers are not available.

83.28(3) Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs *"a"* and *"b."*

441—83.29(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234). The applicant or recipient is entitled to have a review of the level of care determination by the Iowa Foundation for Medical Care by sending a letter requesting a review to the foundation. If dissatisfied with that decision, the applicant or recipient may file an appeal with the department.

441—83.30(249A) Enhanced services. When a household has one person receiving service in accordance with rules set forth in 441—Chapter 24 and another receiving elderly waiver services, the persons providing case management shall cooperate to make the best plan for both clients. When a person is eligible for services as set forth in 441—Chapter 24 and eligible for services under the elderly waiver, the person's primary diagnosis will determine which services shall be used.

441—83.31(249A) Conversion to the X-PERT system. For conversion to the X-PERT system at a time other than review, the recipient may be required to provide additional information. To obtain this information, a recipient may be required to have an interview. Failure to respond for this interview when so requested, or failure to provide requested information, shall result in cancellation.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.32 to **83.40** Reserved.

DIVISION III—HCBS AIDS/HIV WAIVER SERVICES

441—83.41(249A) Definitions.

"AIDS" means a medical diagnosis of acquired immunodeficiency syndrome based on the Centers for Disease Control "Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome," August 14, 1987, Vol. 36, No. 1S issue of "Morbidity and Mortality Weekly Report."

"Client participation" means the amount of the recipient's income that the person must contribute to the cost of AIDS/HIV waiver services exclusive of medical vendor payments before Medicaid will participate.

"Deeming" means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

"Financial participation" means client participation and medical payments from a third party including veterans' aid and attendance.

"HIV" means a medical diagnosis of human immunodeficiency virus infection based on a positive HIV-related test.

"Iowa Foundation for Medical Care" means the entity designated by the federal government to be the peer review organization for the state of Iowa.

"Medical institution" means a nursing facility or hospital which has been approved as a Medicaid vendor.

"Third-party payments" means payments from an attorney, individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

441—83.42(249A) Eligibility. To be eligible for AIDS/HIV waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.42(1) *Eligibility criteria.* All of the following criteria must be met. The person must:

a. Be diagnosed by a physician as having AIDS or HIV infection.

b. Be certified in need of the level of care that, but for the waiver, would otherwise be provided in a nursing facility or hospital. The Iowa Foundation for Medical Care shall be responsible for approval of the certification of the level of care. AIDS/HIV waiver services shall not be provided when the person is an inpatient in a medical institution.

c. Be eligible for medical assistance under SSI, SSI-related, ADC, or ADC-related coverage groups; medically needy at hospital level of care; eligible under a special income level (300 percent group); or become eligible through application of the institutional deeming rules.

d. Require, and use at least quarterly, one service available under the waiver as determined through an evaluation of need described in subrule 83.42(2).

e. Have service needs such that the costs of the waiver services are not likely to exceed the costs of care that would otherwise be provided in a medical institution.

f. Have income which does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

83.42(2) *Need for services.*

a. The county social worker shall perform an assessment of the person's need for waiver services and determine the availability and appropriateness of services. This assessment shall be based, in part, on information in the completed Home- and Community-Based Services Assessment or Reassessment, Form SS-1644. Form SS-1644 shall be completed annually.

b. The total monthly cost of the AIDS/HIV waiver services shall not exceed the established aggregate monthly cost for level of care. The monthly cost of AIDS/HIV waiver services cannot exceed the established limit of $1650.

441—83.43(249A) Application.

83.43(1) *Application for HCBS AIDS/HIV waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.43(2) *Application for services.* Rescinded IAB 12/6/95, effective 2/1/96.

83.43(3) *Approval of application.*

a. Applications for the HCBS AIDS/HIV waiver program shall be processed in 30 days unless one or more of the following conditions exist:

(1) The application is pending because the department has not received information, which is beyond the control of the client or the department.

(2) The application is pending because a level of care determination has not been made or pended although the completed assessment, Form SS-1644, has been submitted to the Iowa Foundation for Medical Care.

(3) The application is pending because the assessment, Form SS-1644, or the case plan has not been completed. When a determination is not completed 90 days from the date of application due to the lack of a completed assessment, Form SS-1644, or case plan, the application shall be denied. The client shall have the right to appeal.

b. Decisions shall be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations and the client case plan are completed.

c. A client must be given the choice between HCBS AIDS/HIV waiver services and institutional care. The income maintenance or service worker shall have the client or guardian complete and sign Form 470-0660, Home- and Community-Based Service Report, indicating the client's choice of home- and community-based services or institutional care.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

83.43(4) *Effective date of eligibility.*

a. The effective date of eligibility for the AIDS/HIV waiver for persons who are already determined eligible for Medicaid is the date on which the income and resource eligibility and level of care determinations and the case plan are completed.

b. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom 441—subrule 75.1(7) and rule 441—75.5(249A) do not apply is the date on which income and resource eligibility and level of care determinations and the case plan are completed.

c. Eligibility for the waiver continues until the recipient has been in a medical institution for 30 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.42(249A). Recipients who are inpatients in a medical institution for 30 or more consecutive days for other than respite care shall be reviewed for eligibility for other Medicaid coverage groups and terminated from AIDS/HIV waiver services if found eligible under another coverage group. The recipient will be notified of that decision through Form SS-1104-0, Notice of Decision. If the client returns home before the effective date of the notice of decision and the person's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

d. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom the eligibility factors set forth in 441—subrule 75.1(7) and, for married persons, in rule 441—75.5(249A) have been satisfied, is the date on which the income eligibility and level of care determinations and the case plan are completed, but shall not be earlier than the first of the month following the date of application.

83.43(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

441—83.44(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of AIDS/HIV waiver services or other Medicaid services, as applicable.

83.44(1) *Maintenance needs of the individual.* The maintenance needs of the individual shall be computed by deducting an amount which is 300 percent of the maximum monthly payment for one person under supplemental security income (SSI) from the client's total income.

83.44(2) *Limitation on payment.* If the amount of the financial participation equals or exceeds the reimbursement established by the service worker for AIDS/HIV services, Medicaid will make no payments to AIDS/HIV waiver service providers. Medicaid will, however, make payments to other medical vendors.

83.44(3) *Maintenance needs of spouse and other dependents.* Rescinded IAB 4/9/97, effective 6/1/97.

441—83.45(249A) Redetermination. A complete redetermination of eligibility for AIDS/HIV waiver services shall be completed at least once every 12 months or when there is significant change in the person's situation or condition. A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.7(249A) and 441—83.42(249A). A redetermination shall include the components listed in rule 441—83.47(249A).

441—83.46(249A) Allowable services. Services allowable under the AIDS/HIV waiver are counseling services, home health aide services, homemaker services, nursing care services, respite care services, home-delivered meals, and consumer-directed attendant care services as set forth in rule 441—78.38(249A).

441—83.47(249A) Case plan. A case plan shall be prepared for AIDS/HIV waiver clients in accordance with rule 441—130.7(234) except that case plans for both children and adults shall be completed every 12 months or when there is significant change in the person's situation or condition. In addition, the case plan shall include the frequency of the AIDS/HIV waiver services and the types or providers who will deliver the services.

441—83.48(249A) Adverse service actions.

83.48(1) Denial. An application for services shall be denied when it is determined by the department that:

a. The client is not eligible for or in need of services.

b. Except for respite care, the AIDS/HIV waiver services are not needed on a regular basis.

c. Service needs exceed the aggregate monthly costs established in 83.42(2)*"b"* or cannot be met by the services provided under the waiver.

d. Needed services are not available from qualified providers.

83.48(2) Termination. Participation in the AIDS/HIV waiver program may be terminated when the department determines that:

a. The provisions of 441—subrule 130.5(2), paragraph *"a," "b," "c," "d," "g,"* or *"h"* apply.

b. The costs of the AIDS/HIV waiver services for the person exceed the aggregate monthly costs established in 83.42(2)*"b."*

c. The client receives care in a hospital or nursing facility for 30 days or more in any one stay for purposes other than respite care.

d. The client receives AIDS/HIV waiver services and the physical or mental condition of the client requires more care than can be provided in the client's own home as determined by the service worker.

e. Service providers are not available.

83.48(3) Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs *"a"* and *"b."*

441—83.49(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234). The applicant or recipient is entitled to have a review of the level of care determination by the Iowa Foundation for Medical Care by sending a letter requesting a review to the foundation. If dissatisfied with that decision, an appeal may be filed with the department.

441—83.50(249A) Conversion to the X-PERT system. For conversion to the X-PERT system at a time other than review, the recipient may be required to provide additional information. To obtain this information, a recipient may be required to have an interview. Failure to respond for this interview when so requested, or failure to provide requested information, shall result in cancellation.

These rules are intended to implement Iowa Code section 249A.4.

441—83.51 to **83.59** Reserved.

DIVISION IV—HCBS MR WAIVER SERVICES

441—83.60(249A) Definitions.

"Adaptive" means age-appropriate skills related to taking care of one's self and one's ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home-living, social skills, community use, self-direction, safety, functional activities of daily living, leisure or work.

"Adult" means a person with mental retardation aged 18 or over.

"Appropriate" means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer's needs, situation, problems, or desires.

"Assessment" means the review of the consumer's current functioning in regard to the consumer's situation, needs, strengths, abilities, desires and goals.

"Behavior" means skills related to regulating one's own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

"Case management services" means those services established pursuant to Iowa Code chapter 225C.

"Child" means a person with mental retardation aged 17 or under.

"Client participation" means the posteligibility amount of the consumer's income that persons eligible through a special income level must contribute to the cost of the home and community-based waiver service.

"Deemed status" means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

"Department" means the Iowa department of human services.

"Direct service" means services involving face-to-face assistance to a consumer such as transporting a consumer or providing therapy.

"Fiscal accountability" means the development and maintenance of budgets and independent fiscal review.

"Health" means skills related to the maintenance of one's health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

"Immediate jeopardy" means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

"Individual comprehensive plan (ICP)" (also known as individual program plan) means a written consumer-centered outcome-based plan of services developed using an interdisciplinary process which addresses all relevant services and supports being provided. It involves more than one agency.

"Individual treatment plan (ITP)" (also known as an individual service plan, individual education plan, and individual habilitation plan) means a written goal-oriented plan of services developed for a consumer by the consumer and the provider agency.

"Intermediate care facility for the mentally retarded (ICF/MR)" means an institution that is primarily for the diagnosis, treatment, or rehabilitation of persons who are mentally retarded and provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or related services to help each individual function at the greatest ability and is an approved Medicaid vendor.

"Intermittent supported community living service" means supported community living service provided not more than 52 hours per month.

"Maintenance needs" means costs associated with rent or mortgage, utilities, telephone, food and household supplies.

"Managed care" means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

"Mental retardation" means a diagnosis of mental retardation under this division which shall be made only when the onset of the person's condition was prior to the age of 18 years and shall be based on an assessment of the person's intellectual functioning and level of adaptive skills. The diagnosis shall be made by a person who is a psychologist or psychiatrist who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person's adaptive skills. A diagnosis of mental retardation shall be made in accordance with the criteria provided in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, published by the American Psychiatric Association.

"Natural supports" means services and supports identified as wanted or needed by the consumer and provider by persons not for pay (family, friends, neighbors, coworkers, and others in the community) and organizations or entities that serve the general public.

"Organization" means the entity being certified.

"Organizational outcome" means a demonstration by the organization of actions taken by the organization to provide for services or supports to consumers.

"Outcome" means an action or event that follows as a result or consequence of the provision of a service or support.

"Procedures" means the steps to be taken to implement a policy.

"Process" means service or support provided by an agency to a consumer that will allow the consumer to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

"Qualified mental retardation professional" means a person who has at least one year of experience working directly with persons with mental retardation or other developmental disabilities and who is one of the following:

1. A doctor of medicine or osteopathy.
2. A registered nurse.
3. An occupational therapist eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.
4. A physical therapist eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.
5. A speech-language pathologist or audiologist eligible for certification of Clinical Competence in Speech-Language Pathology or Audiology by the American Speech-Language Hearing Association or another comparable body or who meets the educational requirements for certification and who is in the process of accumulating the supervised experience required for certification.
6. A psychologist with a master's degree in psychology from an accredited school.
7. A social worker with a graduate degree from a school of social work, accredited or approved by the Council on Social Work Education or another comparable body or who holds a bachelor of social work degree from a college or university accredited or approved by the Council of Social Work Education or another comparable body.
8. A professional recreation staff member with a bachelor's degree in recreation or in a specialty area such as art, dance, music or physical education.
9. A professional dietitian who is eligible for registration by the American Dietetics Association.
10. A human services professional who must have at least a bachelor's degree in a human services field including, but not limited to, sociology, special education, rehabilitation counseling and psychology.

"Staff" means a person under the direction of the organization to perform duties and responsibilities of the organization.

"Third-party payments" means payments from an attorney, individual, institution, corporation, insurance company, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of Medicaid.

441—83.61(249A) Eligibility. To be eligible for HCBS MR waiver services a person must meet certain eligibility criteria and be determined to need a service(s) available under the program.

83.61(1) *Eligibility criteria.* All of the following criteria must be met. The person must:

a. Have a primary diagnosis of mental retardation which shall be updated based on the following time lines:

Age	Initial application to HCBS MR waiver program	Recertification for persons with an IQ range of 54 or below, moderate range of MR or below	Recertification for persons with an IQ range of 55 or above, diagnosis of mild or unspecified range of MR
0 through 17 years	Psychological documentation within three years of the application date substantiating a diagnosis of mental retardation or mental disability equivalent to mental retardation	After the initial psychological evaluation which listed the consumer in this range, substantiate a diagnosis of mental retardation or a diagnosis of mental disability equivalent to mental retardation every six years and when a significant change occurs	After the initial psychological evaluation which listed the consumer in this range, substantiate a diagnosis of mental retardation or mental disability equivalent to mental retardation every three years and when a significant change occurs
18 through 21 years	• Psychological documentation substantiating diagnosis of mental retardation or a diagnosis of mental disability equivalent to mental retardation within three years prior to age 18, or • Diagnosis of mental retardation or mental disability equivalent to mental retardation made before age 18 and current psychological documentation substantiating a diagnosis of mental retardation or a diagnosis of mental disability equivalent to mental retardation	Psychological documentation substantiating a diagnosis of mental retardation or a diagnosis of mental disability equivalent to mental retardation every ten years and whenever a significant change occurs	Psychological documentation substantiating a diagnosis of mental retardation or a diagnosis of mental disability equivalent to mental retardation every five years and whenever a significant change occurs
22 years and above	Diagnosis made before age 18 and current psychological documentation substantiating a diagnosis of mental retardation or a diagnosis of mental disability equivalent to mental retardation, if the last testing date was (1) more than five years ago for consumers with an IQ range of 55 or above or with a diagnosis of mild mental retardation, or (2) more than ten years ago for consumers with an IQ range of 54 or below or with a diagnosis of moderate MR or below	Psychological documentation substantiating a diagnosis of mental retardation or a diagnosis of mental disability equivalent to mental retardation every ten years and whenever a significant change occurs	Psychological documentation substantiating a diagnosis of mental retardation or a diagnosis of mental disability equivalent to mental retardation every five years and whenever a significant change occurs

b. Be eligible for Medicaid under SSI, SSI-related, FMAP, or FMAP-related coverage groups; eligible under the special income level (300 percent) coverage group; or become eligible through application of the institutional deeming rules or would be eligible for Medicaid if in a medical institution.

c. Be certified as being in need for long-term care that, but for the waiver, would otherwise be provided in an ICF/MR. The Iowa Foundation for Medical Care shall be responsible for annual approval of the certification of the level of care based on the data collected by the case manager and interdisciplinary team on a tool designated by the department.

(1) Persons shall have their names placed on the HCBS MR waiver referral list with the division of medical services, or

(2) Currently reside in a residential care facility for the mentally retarded or foster care group home for the mentally retarded, or

(3) Currently reside in an ICF/MR or nursing facility.

d. Be a recipient of the Medicaid case management services or be identified to receive Medicaid case management services immediately following program enrollment.

e. Have service needs that can be met by this waiver program. At a minimum, an adult must receive one unit of either consumer-directed attendant care, supported community living, respite, or supported employment service per calendar quarter. Children shall, at a minimum, receive one unit of either consumer-directed attendant care, respite service or supported community living service per calendar quarter under this program.

f. Have an individual comprehensive plan completed annually.

g. For supported employment services:

(1) Be at least age 18.

(2) Rescinded IAB 7/1/98, effective 7/1/98.

(3) Not be eligible for supported employment service funding under Public Law 94-142 or for the Rehabilitation Act of 1973.

(4) Not reside in a medical institution.

h. Have an individual comprehensive plan or service plan approved by the department.

83.61(2) *Need for services.*

a. Consumers currently receiving Medicaid case management or services of a department-qualified mental retardation professional (QMRP) shall have the applicable coordinating staff and other interdisciplinary team members complete the Functional Assessment Tool, Form 470-3073, and identify the consumer's needs and desires as well as the availability and appropriateness of the services.

b. Consumers not receiving services as set forth in paragraph *"a"* who are applying for the HCBS MR waiver service shall have a department service worker or a case manager paid by the county without Medicaid funds complete the Functional Assessment Tool, Form 470-3073, for the initial level of care determination; establish an initial interdisciplinary team for HCBS MR services; and, with the initial interdisciplinary team, identify the consumer's needs and desires as well as the availability and appropriateness of services.